

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER
09-02

2. STATE
Virgin Islands

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY
ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2009

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION
1902(a)(69) of the Act

7. FEDERAL BUDGET IMPACT

a. FFY 2009 \$ 0
b. FFY 2010 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A page 1A
Attachment 3.1-A page 2
Attachment 3.1-A page 12A
Attachment 3.1-B page 2
Attachment 3.1-B page 15-16
Attachment 3.1-B page 14-14A

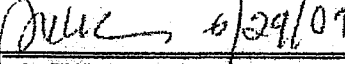
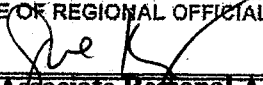
***** SEE REMARKS**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR
ATTACHMENT (*If Applicable*)

Attachment 3.1-A page 1A
Attachment 3.1-A page 2
Attachment 3.1-B page 2
Attachment 3.1-B page 15-16
Attachment 3.1-B page 14-14A

10. SUBJECT OF AMENDMENT

Clarifies coverage provisions, including but not limited to prior authorization requirements, in the areas of EPSDT services, FQHC services, laboratory and X-ray services, family planning services, dentures, and prosthetic devices

11. GOVERNOR'S REVIEW (Check One)	
GOVERNORS OFFICE REPORTED NO COMMENT	X OTHER, AS SPECIFIED
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	
12. SIGNATURE OF STATE AGENCY OFFICIAL  6/29/09	18. RETURN TO: Julia Sheen
13. TYPED NAME Julia Sheen	DOH, BHIMA
14. TITLE Acting Commissioner, Department of Health	3500 Richmond
15. DATE SUBMITTED 06/29/2009	Charles Harwood Complex
	Christiansted, USVI 00820
FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED	18. DATE APPROVED DEC 01 2009
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL APR 01 2009	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Sue Kelly	22. TITLE Associate Regional Administrator Division of Medicaid and State Operations
22. REMARKS Originally submitted SPA was divided into 5 SPAs. Originally submitted pages were replaced with new pages via State's e-mail on 11/16/09. Attachment 3.1-A, Page 1, Page 7, Page 10, Page 10A, Page 11, Page 11A, and Page 13. Attachment 3.1-B, Page 2, Page 6, Page 13, Page 14, Page 14A, and Page 15. Attachment 4.19-B, Page 4.	